STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3)residents, (Resident #1), reviewed for elopement, the facility failed to supervise a resident who required assistance with ambulation resulting in the resident leaving facility grounds unsupervised The findings include: Resident #1's diagnoses included alcohol abuse, muscle weakness, difficulty in walking and a history of falling. The admission nursing assessment dated [DATE] identified Resident #1 was alert with some forgetfulness, exhibited short-term memory loss and required assistance due to decreased range of motion in both the upper and lower extremities. The Resident Care Plan (RCP) dated 9/9/24 identified that Resident #1 required assistance with Activities of Daily Living (ADL's) with interventions that included to assist with bathing, dressing, hygiene, transfers and ambulation as ordered. Review of the Elopement Evaluation dated 9/7/24 at 8:37 PM identified that Resident #1 was not at risk for elopement. A physician's order dated 9/9/24 directed that Resident #1 ambulates with a rolling walker and an assist of one. Review of Occupational Therapy Treatment Encounter Note dated 9/9/24 identified that resident requires 24/7 supervision and assist of one with ADLs with the use of a rolling walker. A nurse's note dated 9/12/24 at 5:40 PM identified that at 4:00 PM, a call was received from MD #1, who reported he observed Resident #1 wandering away from the facility independently. The nurse's note identified that the Admissions Director, DNS, RN #1 and PTA #1 (Rehab Director) exited the facility to aide the resident and he/she was guided back towards the facility driveway, assisted into a transport wheelchair and brought back into the facility. A wander guard was immediately placed upon the resident's left ankle upon re-entry and Resident #1 was then transported back to his/her unit and seated in a chair across from the nursing station. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with OT #1 on 10/7/24 at 12:01 PM identified that she had seen Resident #1 for a start of care evaluation on 9/9/24 and for safety, the resident was made an assist of one for supervision with a walker due to cognition. She reported that the resident was not safe to be ambulating independently. Interview with Receptionist #2 on 10/7/24 at 3:44 PM identified that she was the receptionist on duty on 9/12/24 starting at 3:00 PM, reporting that she received a phone call from MD #1 at around 3:45 PM stating that there was an elderly person at the end of the driveway. She identified that she immediately notified the Admissions Director first because she was directly behind her and then called the DNS, reporting that they went out to the front entrance immediately. Receptionist #2 reported that she did not observe any residents going out the front door between 3:00 PM and 4:00 PM and that there were several residents sitting on the front porch when she came in for her shift. She identified that that she has been requested by administration to watch the residents that are outside on the front porch, as the window is right next to her, but reported that it is very difficult to keep an eye on them while also answering the phones and talking with people who come up to her desk with questions. Interview with MD #1 (wound physician) on 10/7/24 at 1:36 PM identified that when he was driving out of the facility, he observed an elderly male towards the exit of the facility and at first he thought nothing of it because some residents have privileges to walk the grounds of the facility. He reported he did not recognize the male and was unsure if it was a resident, a family member or a visitor at the time. He identified that after he was about 20 seconds away from the facility, he had an uneasy feeling about the observation he made and felt that something wasn't right, so he called the facility and reported it to the receptionist. Interview with the Admissions Director on 10/7/24 at 12:22 PM identified that Receptionist #2 notified her on 9/12/24 around 4:00 PM that she received a call from MD #2 (wound physician) stating there was a resident outside at the end of the driveway. She reported that she immediately ran outside and located Resident #1 on the right-hand side of the road, almost to the stop sign an intersection talking with the mailman. She identified that she called the Administrator from her cellphone to notify her and stayed with the resident, who was easily redirectable and agreed not to walk any further. She reported that the DNS, RN #1 and PTA #1 arrived to assist within one to two minutes and reported that they took over and she went back into the building. Interview with LPN #1 on 10/7/24 at 11:06 AM identified that she was the nurse assigned to Resident #1 9/12/24 for the 7:00 AM to 3:00 PM shift. She reported that Resident #1 was new to the facility but from what she observed he/she was pleasant and enjoyed sitting in the hallway and conversing with others in the area. She identified that the resident had not been wandering or trying to exit the building on the 7:00 AM to 3:00 PM shift on 9/12/24. She was unable to identify the time she had last seen the resident, but reported it was sometime after lunch. Interview with NA #1 on 10/7/24 at 11:36 AM identified that he was the NA assigned to Resident #1 on the 7:00 AM to 3:00 PM shift on 9/12/24. He reported that the resident was friendly and enjoyed walking the halls, walking to the recreation room and sitting outside, but that he/she always went back to their room afterwards and he had never heard the resident reporting he/she wanted to leave the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 10/7/24 at 10:20 AM identified that she received a call from Receptionist #2 around 4:00 PM on 9/12/24 requesting assistance with a resident who was observed walking down the driveway and into the road. She identified that she immediately exited the building with RN #1 and PTA #1 (Rehab Director) and observed Resident #1 to the right side of the road at a intersection, accompanied by the Admissions Director. She identified that the resident was pleasant and agreeable to all direction and was then assisted into the wheelchair, a wander guard was placed to his/her left ankle for safety. The DNS further identified that she was unaware that Resident #1 had a physician's order directing that the resident was to ambulate with a rolling walker and an assist of one. She reported that the receptionist will watch out the front window and keep an eye on any residents that are sitting outside who do not require assistance. She identified that per physician's orders, Resident #1 should not have been sitting outside unattended and should not have been ambulating independently, reporting that she expects nursing staff to follow physician's orders and a staff member should have been with the resident. Although requested, a facility policy for following physician's orders was not provided.